

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003084

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 8

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>Breckenridge Hills</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>3470 Royalton</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Oliver</u> Last <u>Oliver</u>		4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>79</u>
11a. FATHER'S NAME <u>Pete Downs</u>		11b. MOTHER'S MAIDEN NAME <u>Anna Mahanes</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		14. NAME OF HUSBAND OR WIFE <u>Harvey S. Oliver</u>	
15. SOCIAL SECURITY NO. <u>[REDACTED]</u>		16. INFORMANT <u>Harvey S. Oliver, 3470 Royalton</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>5</u> a.m. Month, Day, Year <u>1949</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>1963</u>
21. I attended the deceased from <u>1949</u> to <u>1963</u> and last saw her alive on <u>Jan 5 1963</u> Death occurred at <u>5 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>Paula B. Vatterott M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>1-8-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery City Cem.</u>
24. FUNERAL DIRECTOR <u>Drehmann-Harral, 1905 Union Bl.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 5, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
27. ADDRESS <u>St. Louis, Mo.</u>		28. LOCATION (City, town, or county) <u>Montgomery City Mo.</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

1/5/63

JAN 21 1963

Dr. J. M. Vatterott
10300 St. Charles Rock Rd.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address

H. J. Davis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.